STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515199	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summersville Healthcare Center	712 Professional Park Drive Summersville, WV 26651

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 50551 Based on resident interview, observation, record interview and staff interview, the facility failed to ensure the call light was accessible to Resident #55 and to have sufficient equipment to ensure Resident #25 could get out of bed to attend Resident Council. This was a random opportunity for discovery. Resident identifier: #55, #25 Facility Census 88. Findings included: a) Resident #55 On 11/11/24 at 3:20 PM, Resident was in room in wheelchair and stated that she wanted to go to bed. Her call light was on the bed and not within reach. On 11/11/24 3:22 PM, an interview with Nurse Aide (NA) #40 who acknowledged that the call light was not in the reach of the resident. She picked up the resident's call light and handed it to her stating, I'm sorry Ms. (resident's name) I did not know you did not have your call light. On 11/12/24 at 1:00 PM review of resident's records revealed the following: Care plan- Focus Activities of Daily Living (ADL) Self Care Performance deficit, requires staff assistance with ADL's related to impaired mobility, non-ambulatory, generalized weakness, generalized weakness, arthritis, pain, decreased ROM left knee. 6/25/24, revision 9/18/24 Focus Resident is at risk for falls related to history of falls at home, impaired mobility, poor safety awareness. date 6/25/25, revised 07/05/24 Interventions included: Place call bell within reach, remind resident to call for assistance. 09/16/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Resident #25 On 11/11/24 at 3:40 PM an interview was conducted with Resident #25 who reported that she had just gotten out of bed because she had to wait for the lift in order for staff to assist her in getting up. She reported she was [NAME] President of the Resident Council and was unable to attend the resident council meeting held today and the veterans program held directly after. She reported that staff had to share the lift with other residents and sometimes had difficulty finding the pads (chair) portion of the lift. She reported she enjoys attending activities and often does all the talking to stand up for herself and other residents. On 11/11/24 at 3:49 PM, an interview with NA #40 who reported that there are two (2) lifts per floor. She stated that the wing in which Resident #25 resides on was originally meant to be a memory unit with residents who did not require a lift. As a result, they have more residents that require a lift causing them to need to share with other hallways. She stated the pads (chair) portion of the lift can often be difficult to find. Staff will sometimes hide them in residents' rooms so they don't have to look for them when they need to use them making it difficult for others to use the lift. She stated that in today's case, staff were unable to use the lift to assist Resident #25 out of bed for her activities because she could not find the lift pad in the storage closet and when she recovered one from laundry, it was still drying and not safe to use at that time. She acknowledged that resident did not get to attend her activities today because the facility was unable to get her out of bed. On 11/12/24 at 2:30 a review of Resident # 25's records revealed the following: Physician's Orders reveal that resident is to be transferred via mechanical lift with (two) 2 assist. active since 10/02/24. Care Plan revealed the following: Focus ADL Self Care Performance deficit, requires assistance with ADL, history of Cerebrovascular Accident with right sided weakness, non-ambulatory. Date initiated: 07/05/23 Revision on: 10/02/24 Interventions included: Transfers via mechanical lift X 2 staff assist. Focus Strength: Resident is able to voice activity preference. Goal Resident will attend BINGO and/or church or church related activities 4-5 times a week and will have puzzles and other activities of interest 4-5 times a week. Interventions/Task - Included (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist with transport to activities as needed. Date initiated 07/10/23 Invite resident to scheduled activities.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 49467 Based on record review and resident, family, and staff interview, the facility failed to honor Resident #30's choices by ensuring she was able to leave the facility with family members, by not allowing her to leave, due to the fact she is on oxygen. This was true for one (1) of one (1) residents reviewed for choices during the survey process. Resident identifier: #30. Facility census: 88. Findings included: A) Resident #30 At approximately 1:45 PM on 11/11/24, an interview was conducted with Resident #30. During the interview, Resident #30 stated I'm not allowed to leave the building with my oxygen tank. I was supposed to go to my house and they wouldn ' t let me leave. About three (3) weeks ago, my daughter came to pick me up, and when I started to leave, (Licensed Practical Nurse [LPN] #37's name) stood up and told me I was not allowed to leave with my oxygen tank. She called the head nurse and then a nurse from upstairs came down and told me I could not leave the building with my oxygen tank. It's like a prison here. At approximately 1:00 PM on 11/13/24, an interview was conducted with the daughter of Resident #30. During the interview, the daughter stated There's a nurse there that picks on my mom, her name is (LPN #37's name). A few weeks ago I came to pick her up to take her out for a few hours. They gave her her medications and when we got to the nurse's desk, (LPN #37's name) stood up and told us we couldn't leave the building because we could not take the tanks out. (LPN #37's name) said it was against regulations for us to take the tanks out of the building. We have taken them out before with no issues. Resident #30's daughter stated, at one time, the facility would let her mother leave and give her extra tanks to take with her. She stated Resident #30 didn't get to go out that day and went back to her room. She described her mother's mood as very disappointed and upset. At approximately 12:20 PM on 11/14/24, and interview was conducted with the first floor Registered Nurse Unit Manager (RNUM) regarding Resident #30. During the interview, the RNUM stated It was on a weekend when she wanted to go out with her daughter and they called me about her wanting to take a tank with her. I told them we don't have a portable concentrator and there was no way for her to safely transport the tanks to and from the facility, so she couldn't go. If they were to wreck and blow up while they were out with the tanks, that would be on my conscience. I verified with (Director of Nursing's [DON] name) that we don't send out the oxygen tanks with residents. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 12:35 PM on 11/14/24, an interview was conducted with the Administrator and DON regarding Resident #30. During the interview, the DON stated the facility, at the time, did not have a portable oxygen tank for the resident to use if they wanted to leave the facility. The DON stated she remembered getting a call the day Resident #30 wanted to leave with her daughter, and confirmed she was not allowed to leave the facility, because they would not let her take a portable tank. The DON stated as the holidays approach, they are expecting multiple residents to go on leave with their families and have been in contact with representatives from companies to secure portable concentrators to take with them. The DON stated they request the residents give them a couple days notice if they intended to go on a leave with their families so they could get portable concentrators for them to take. When asked if it was an emergency situation, if the resident would be able to leave the facility with family, the administrator stated If it were an emergency, we would find a way for them to leave. When asked if it a resident was allowed to leave the facility, if they were on oxygen, during the timeframe this incident occurred with Resident #30, the DON stated No. Asked if a family member showed up spontaneously and requested to take a family member out during this time, if the resident would be allowed to leave, if they were on oxygen, the DON stated No. At approximately 1:03 PM on 11/14/24, an interview was conducted with LPN #37. LPN #37 stated she called the DON and was told there was no safe way to transport the oxygen tanks, therefore Resident #30 could not leave the facility with her daughter. LPN #37 stated they educate families on medications and the importance of taking them correctly on leave of absence from the facility, but confirmed they do not provide education on oxygen transportation. During record review, it was determined Resident #30 has physician orders for 2 units of oxygen continuously. It was noted, during a review of the facility's leave of absence sign out sheet, that residents or responsible parties must sign before they leave, there is a declaration by the facility noting the facility is not responsible for any events that occur when the resident is on leave.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 51553 Based on record review and staff interview, the facility failed to provide Resident #74 the right to private communication and ensure mail was delivered on Saturdays. This failed practice has the potential to affect more than a limited number of residents. Resident identifier: #74. Facility Census: 88. Findings included: a) Resident #74 On 11/11/24 - During the Resident Council meeting, Resident #74 reported he does not get mail on Saturdays. He stated he gets the previous Sunday's church bulletin usually on Mondays. The Activities Director reported that sometimes the mail is dropped under the ledge on Saturdays and the mail is not always delivered. On 11/12/24 at 11:35 AM - The State Surveyor interviewed the Director of Nursing and the Nursing Home Administrator concerning Resident Council Concerns. The Nursing Home Administrator reported the Activities Director was in the process of educating the activities staff on this date to deliver the resident's personal mail on Saturdays. On 11/14/24 at 10:40 AM - Record review of the Policies and Procedures for Resident's Rights stated the resident has the right to Have privacy in sending and getting mail and email.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45173 Based on record review and staff interview, the facility failed to implement a care plan regarding taking blood pressures in a restricted arm for Resident #24 and #28. This was true for two (2) of 32 care plans reviewed during the survey process. Resident Identifiers: #24 and #28. Facility Census: 88. Findings Included: a) Resident #24 On 11/13/24 at 2:12 PM, a record review was completed for Resident #24. The review found under the focus area of ADL (activities of daily living) self care performance deficit, an intervention listed as NO blood pressures or needle sticks to Left arm due to hx (history) of mastectomy. (Typed as written.) A review under the vital sign tab found 10 documented times the blood pressure was taken in the restricted arm in the last three (3) months. The following dates and times were documented: --11/02/24 06:40 138 / 80 mmHg Lying l/arm --10/24/24 11:17 122 / 70 mmHg Sitting l/arm --10/20/24 14:31 109 / 66 mmHg Sitting l/arm --10/17/24 10:13 127 / 60 mmHg Lying l/arm --10/01/24 19:21 134 / 59 mmHg Lying l/arm --09/20/24 09:05 110 / 74 mmHg Lying l/arm --09/19/24 22:18 131 / 74 mmHg Sitting l/arm --09/19/24 09:44 136 / 75 mmHg Lying l/arm --08/24/24 07:30 140 / 56 mmHg Lying l/arm --08/07/24 07:33 111 / 68 mmHg Lying l/arm On 11/13/24 at 3:00 PM, the Director of Nursing (DON) was notified. The DON confirmed the blood pressures should not have been taken in the restricted arm. b) Resident #28 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 2:05 PM on 11/12/24, during a review of Resident #28's record, it was determined the resident had an order for no blood pressures to be taken in her left arm, due to a mastectomy. Resident #28 has an order entered for the blood pressures, which reads as follows: Blood pressures to be done on right side due to breast mastectomy.No directions specified for order. Resident #28 is also care planned for no blood pressures or lab draws from her left arm due to a mastectomy. During review it was found the facility took blood pressures in Resident #28's left arm 58 times since 10/01/24 During an interview with Licensed Practical Nurse (LPN) #120 at approximately 2:15 PM on 11/12/24, she acknowledged she takes Resident #28's blood pressure in her left arm. During review, the following dates were noted that Resident #28 had blood pressures taken from her left arm. The following instances are typed as written in the resident's record: 11/13/24 10:26 120 / 59 mmHg Sitting l/arm 11/12/24 23:22 130 / 55 mmHg Sitting l/arm 11/12/24 11:47 110 / 70 mmHg Sitting l/arm 11/11/24 10:22 133 / 56 mmHg Sitting l/arm 11/11/24 00:09 143 / 53 mmHg Sitting l/arm 11/7/24 11:45 116 / 53 mmHg Sitting l/arm 11/6/24 20:14 126 / 44 mmHg Lying l/arm 11/6/24 17:19 125 / 64 mmHg Sitting l/arm 11/2/24 07:42 131 / 58 mmHg Lying l/arm 10/30/24 19:31 132 / 60 mmHg Sitting l/arm 10/28/24 03:00 103 / 59 mmHg Sitting l/arm 10/27/24 14:57 131 / 61 mmHg Lying l/arm 10/25/24 15:04 118 / 56 mmHg Lying l/arm 10/25/24 07:05 129 / 69 mmHg Lying l/arm 10/23/24 10:33 128 / 54 mmHg Sitting l/arm (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/21/24 07:44 121 / 58 mmHg Sitting l/arm 10/19/24 17:48 124 / 54 mmHg Sitting l/arm 10/19/24 10:24 117 / 57 mmHg Sitting l/arm 10/17/24 09:02 120 / 69 mmHg Sitting l/arm 10/17/24 05:55 118 / 68 mmHg Lying l/arm 10/17/24 05:22 123 / 61 mmHg Lying l/arm 10/17/24 04:21 125 / 67 mmHg Lying l/arm 10/17/24 03:30 133 / 60 mmHg Lying l/arm 10/17/24 02:12 131 / 57 mmHg Lying l/arm 10/17/24 01:28 140 / 62 mmHg Lying l/arm 10/17/24 00:42 120 / 61 mmHg Sitting l/arm 10/16/24 23:30 116 / 55 mmHg Lying l/arm 10/16/24 22:04 102 / 59 mmHg Sitting l/arm 10/16/24 21:40 111 / 61 mmHg Sitting l/arm 10/16/24 20:29 142 / 59 mmHg Lying l/arm 10/16/24 18:55 108 / 56 mmHg Sitting l/arm 10/16/24 18:55 110 / 60 mmHg Sitting l/arm 10/16/24 17:02 112 / 58 mmHg Sitting l/arm 10/16/24 16:43 98 / 38 mmHg Sitting l/arm 10/16/24 15:04 94 / 32 mmHg Sitting l/arm 10/16/24 14:55 108 / 48 mmHg Sitting l/arm 10/16/24 13:04 109 / 55 mmHg Lying l/arm 10/16/24 12:45 126 / 72 mmHg Lying l/arm 10/16/24 11:44 118 / 68 mmHg Lying l/arm (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/16/24 10:25 127 / 65 mmHg Lying l/arm 10/16/24 09:30 142 / 68 mmHg Lying l/arm 10/16/24 08:21 123 / 61 mmHg Lying l/arm 10/16/24 07:20 121 / 65 mmHg Lying l/arm 10/16/24 06:22 140 / 72 mmHg Lying l/arm 10/16/24 05:21 130 / 64 mmHg Lying l/arm 10/16/24 04:58 132 / 72 mmHg Lying l/arm 10/16/24 02:28 124 / 60 mmHg Sitting l/arm 10/16/24 02:12 116 / 64 mmHg Sitting l/arm 10/16/24 01:58 129 / 71 mmHg Sitting l/arm 10/16/24 00:25 116 / 64 mmHg Sitting l/arm 10/15/24 23:19 116 / 64 mmHg Sitting l/arm 10/15/24 15:49 179 / 76 mmHg Sitting l/arm 10/10/24 01:04 138 / 94 mmHg Sitting l/arm 10/6/24 23:55 122 / 56 mmHg Lying l/arm 10/6/24 01:04 165 / 52 mmHg Lying l/arm 10/3/24 11:56 148 / 66 mmHg Lying l/arm 10/2/24 11:45 161 / 68 mmHg Sitting l/arm 10/1/24 10:31 117 / 74 mmHg Sitting l/arm The Director of Nursing (DON) acknowledged these instances on 11/14/24 at approximately 1:15 PM. 49467

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 45173 49467 Based on observation, record review and staff interview, the facility failed to follow a physician's order regarding blood pressure checks in a restricted arm due to a mastectomy for Residents #28 and #24, and to follow physician orders for Resident #88's fall safety devices to assist in prevention of injury for a resident with a diagnosis and history of repeated falls. This was true for three (3) of 32 reviewed during the survey process. Resident Identifier: #28, #24, #88. Facility Census: 88. Findings included: a) Resident #28 At approximately 2:05 PM on 11/12/24, during a review of Resident #28's record, it was determined the resident had an order for no blood pressures to be taken in her left arm, due to a mastectomy. Resident #28 has an order entered for the blood pressures, which reads as follows: Blood pressures to be done on right side due to breast mastectomy. No directions specified for order. Resident #28 is also care planned for no blood pressures or lab draws from her left arm due to a mastectomy. During review it was found the facility took blood pressures in Resident #28's left arm 58 times since 10/01/24 During an interview with Licensed Practical Nurse (LPN) #120 at approximately 2:15 PM on 11/12/24, she acknowledged she takes Resident #28's blood pressure in her left arm. During review, the following dates were noted that Resident #28 had blood pressures taken from her left arm. The following instances are typed as written in the resident's record: 11/13/24 10:26 120 / 59 mmHg Sitting l/arm 11/12/24 23:22 130 / 55 mmHg Sitting l/arm 11/12/24 11:47 110 / 70 mmHg Sitting l/arm 11/11/24 10:22 133 / 56 mmHg Sitting l/arm 11/11/24 00:09 143 / 53 mmHg Sitting l/arm 11/7/24 11:45 116 / 53 mmHg Sitting l/arm 11/6/24 20:14 126 / 44 mmHg Lying l/arm (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/6/24 17:19 125 / 64 mmHg Sitting l/arm 11/2/24 07:42 131 / 58 mmHg Lying l/arm 10/30/24 19:31 132 / 60 mmHg Sitting l/arm 10/28/24 03:00 103 / 59 mmHg Sitting l/arm 10/27/24 14:57 131 / 61 mmHg Lying l/arm 10/25/24 15:04 118 / 56 mmHg Lying l/arm 10/25/24 07:05 129 / 69 mmHg Lying l/arm 10/23/24 10:33 128 / 54 mmHg Sitting l/arm 10/21/24 07:44 121 / 58 mmHg Sitting l/arm 10/19/24 17:48 124 / 54 mmHg Sitting l/arm 10/19/24 10:24 117 / 57 mmHg Sitting l/arm 10/17/24 09:02 120 / 69 mmHg Sitting l/arm 10/17/24 05:55 118 / 68 mmHg Lying l/arm 10/17/24 05:22 123 / 61 mmHg Lying l/arm 10/17/24 04:21 125 / 67 mmHg Lying l/arm 10/17/24 03:30 133 / 60 mmHg Lying l/arm 10/17/24 02:12 131 / 57 mmHg Lying l/arm 10/17/24 01:28 140 / 62 mmHg Lying l/arm 10/17/24 00:42 120 / 61 mmHg Sitting l/arm 10/16/24 23:30 116 / 55 mmHg Lying l/arm 10/16/24 22:04 102 / 59 mmHg Sitting l/arm 10/16/24 21:40 111 / 61 mmHg Sitting l/arm 10/16/24 20:29 142 / 59 mmHg Lying l/arm 10/16/24 18:55 108 / 56 mmHg Sitting l/arm (continued on next page)

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	515199	A. Building B. Wing	11/14/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/16/24 18:55 110 / 60 mmHg Sitting l/arm 10/16/24 17:02 112 / 58 mmHg Sitting l/arm 10/16/24 16:43 98 / 38 mmHg Sitting l/arm 10/16/24 15:04 94 / 32 mmHg Sitting l/arm 10/16/24 14:55 108 / 48 mmHg Sitting l/arm 10/16/24 13:04 109 / 55 mmHg Lying l/arm 10/16/24 12:45 126 / 72 mmHg Lying l/arm 10/16/24 11:44 118 / 68 mmHg Lying l/arm 10/16/24 10:25 127 / 65 mmHg Lying l/arm 10/16/24 09:30 142 / 68 mmHg Lying l/arm 10/16/24 08:21 123 / 61 mmHg Lying l/arm 10/16/24 07:20 121 / 65 mmHg Lying l/arm 10/16/24 06:22 140 / 72 mmHg Lying l/arm 10/16/24 05:21 130 / 64 mmHg Lying l/arm 10/16/24 04:58 132 / 72 mmHg Lying l/arm 10/16/24 02:28 124 / 60 mmHg Sitting l/arm 10/16/24 02:12 116 / 64 mmHg Sitting l/arm 10/16/24 01:58 129 / 71 mmHg Sitting l/arm 10/16/24 00:25 116 / 64 mmHg Sitting l/arm 10/15/24 23:19 116 / 64 mmHg Sitting l/arm 10/15/24 15:49 179 / 76 mmHg Sitting l/arm 10/10/24 01:04 138 / 94 mmHg Sitting l/arm 10/6/24 23:55 122 / 56 mmHg Lying l/arm 10/6/24 01:04 165 / 52 mmHg Lying l/arm (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515199	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summersville Healthcare Center	712 Professional Park Drive Summersville, WV 26651

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/3/24 11:56 148 / 66 mmHg Lying l/arm 10/2/24 11:45 161 / 68 mmHg Sitting l/arm 10/1/24 10:31 117 / 74 mmHg Sitting l/arm The Director of Nursing (DON) acknowledged these instances on 11/14/24 at approximately 1:15 PM. b) Resident #24 On 11/13/24 at 2:12 PM, a record review was completed for Resident #24. The review found a physician's order dated 11/03/23 stating, No BP (blood pressure) or blood draws from [LEFT] arm every shift for mastectomy safety. (Typed as written.) A review under the vital sign tab found 10 documented times the blood pressure was taken in the restricted arm in the last three (3) months. The following dates and times were documented: --11/02/24 06:40 138 / 80 mmHg Lying l/arm --10/24/24 11:17 122 / 70 mmHg Sitting l/arm --10/20/24 14:31 109 / 66 mmHg Sitting l/arm --10/17/24 10:13 127 / 60 mmHg Lying l/arm --100/1/24 19:21 134 / 59 mmHg Lying l/arm --09/20/24 09:05 110 / 74 mmHg Lying l/arm --09/19/24 22:18 131 / 74 mmHg Sitting l/arm --09/19/24 09:44 136 / 75 mmHg Lying l/arm --08/24/24 07:30 140 / 56 mmHg Lying l/arm --08/07/24 07:33 111 / 68 mmHg Lying l/arm On 11/13/24 at 3:00 PM, the Director of Nursing (DON) was notified. The DON confirmed the blood pressures should not have been taken in the restricted arm. c) Resident #88 During an observation on 11/13/24 at 1:35 PM Resident #88 was sitting in her wheelchair at the nurse's desk. The resident was assisted to her room by nursing staff. Nurse #73 verified the resident did not have her lumbar sacral support or hipsters on while up in her wheelchair. The resident stated, I took those off. and I don't like them. The resident's hipsters were observed in the bathroom. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 1:42 PM during an interview Unit Nurse #15 stated the resident takes her lumbar sacral support and hipsters off. Unit Nurse #15 said the resident dressed and undressed herself, and transfered at times by herself. Unit Nurse #15 stated she thought the sacral support was PRN (as needed) and she would follow-up. On 11/13/24 at 2:50 PM Unit Nurse #15 stated she found the lumbar sacral support in a drawer under a blanket and the lumbar sacral support was not ordered PRN. On 11/14/24 at 9:00AM - The State Surveyor interviewed the Director Of Nursing concerning orders for Resident #88 to wear lumbar sacral support and hipsters. The Director Of Nursing stated the resident is non-compliant and takes them off. The Director Of Nursing stated, We just have to wait and put them back on. 51553

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45173 Based on observation, record review and staff interview, the facility failed to provide an accident and hazard free environment as possible by having medication at bedside without a physician's order. This was a random opportunity for discovery. Resident Identifier: #68. Facility Census: 88. Findings Included: a) Resident #68 On 11/11/24 at 12:10 PM, an interview was held with Resident #68. During the interview, an observation was made of a bottle of artificial tears at bedside. On 11/13/24 at 3:55 PM, an additional observation was made of a bottle of artificial tears at bedside. On 11/13/24 at 4:00 PM, a review of the record found the resident did not have a physician's order for artificial tears as well as may be kept at bedside. On 11/13/24 at 4:03 PM, Nurse Aide (NA) #21 was interview regarding the artificial tears at bedside. NA #21 stated, I didn't see those in her room .no she shouldn't have those in there. On 11/13/24 at 4:30 PM, the Director of Nursing (DON) was notified of the artificial tears at bedside. The DON confirmed the artificial tears should not be at bedside. The DON stated, we called the son and he said he brought them in .he didn't know the rules. The DON, also, confirmed there was not a physician's order for the medication. The DON stated, we called the physician to obtain an order.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 Based on record review and staff interview, the facility failed to ensure the appropriate party signed Resident #91's Physician Orders for Scope of Treatment (POST) form. True for 1 of 32 reviewed for advance directives. Resident identifier, resident #91. Findings included: On [DATE] a review of resident's records revealed that Resident #91's POST form was signed by Medical Power of Attorney (MPOA) on [DATE] when resident had capacity. Physician's Determination of Capacity dated [DATE] revealed the following: Demonstrates capacity West Virginia POST Form dated [DATE] revealed No CPR, Selective Treatments, No artificial Means of nutrition desired. Signed by MPOA and not resident. An interview with DON on [DATE] at 3:00 PM who acknowledged that resident did have capacity when the MPOA signed her POST form.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49467 Based on observation and resident interview, the facility failed to provide meals that were palatable and appetizing for residents of the facility. This has the potential to affect more than a limited number of residents. Resident identifiers: #37, #30, #16, #39, #68, #6, #74, #46. Facility census: 88. Findings included: a) Resident Interviews During the survey process, multiple surveyors obtained interviews from residents at the facility regarding the food served. The interviews are as follows: Approximately 9:56 AM on 11/12/24- Resident #37's Power of Attorney (POA) states The food is mediocre, at best. Approximately 2:04 PM on 11/11/24- Resident #30 stated The food is awful. You can't chew it. You have to eat some of it though, or else you'll get sick. Approximately 10:36 AM on 11/12/24- Resident #16 stated The food is not good. Approximately 1:39 PM on 11/11/24- Resident #39 stated The food sucks. Approximately 12:10 PM on 11/11/24- Resident #68 stated The food is a disaster, I got a hot dog on a plate with nothing else. Approximately 12:00 PM on 11/11/24 - Resident #6 stated Meals are always late--don't get it until 6:30 PM or later. No drinks, no silverware, the meat is tough and you can't chew it. Approximately 12:15 PM at 11/11/24 - Resident #74 stated Sometimes it's good, sometimes bad, last night my baked potato was cold for dinner. Several times they have sent the bun but no meat on the bun. Approximately 1:07 PM on 11/11/24 - Resident #46 stated Sometimes it's pretty good and sometimes it's pretty bad. b) Test Tray At approximately 1:00 PM on 11/12/24 test trays were requested from the kitchen. The main meal for the day was smothered chicken thigh, lima beans, whipped sweet potatoes, and cornbread. The alternate meal was rancher's pork chop, sliced carrots, mashed potatoes and gravy, and cornbread. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Five (5) out of six (6) surveyors tasted the meals. Consensus among the surveyors were the pork chops were tough to cut and chew, the meat was very tough. The whipped sweet potatoes, mashed potatoes, and carrots were bland, with no favor. The cornbread on the pork chop tray was placed on the tray, and was sitting in gravy from the pork chop and mashed potatoes, causing it to be soggy. At approximately 2:30 PM on 11/12/24 an interview was conducted with the Culinary Director (CD) about the palatability and presentation of the food. The CD stated the facility usually serves cornbread in a bag, separately from the rest of the tray to attempt to avoid this situation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49467 Based on observation and staff interviews, the facility failed to ensure equipment in which they prepared food, was kept clean and sanitary. This has the potential to affect more than a limited number of residents. This was a random opportunity for discovery. Facility census: 88. Findings included: a) Oven At approximately 11:25 AM on 11/11/24, during a tour of the kitchen, the oven was noted to have grease covering the windows. Upon inspection of the inside of the oven, there was noted to be spillage and grease inside the oven. Pieces of food were laying on the floor of the oven. The Culinary Director (CD) was asked how often the oven was cleaned. The CD stated the oven was cleaned once a week or once every two weeks. When asked if the oven is cleaned upon noticing spillage, as was evident, the CD stated It should be.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45173 49467 49751 Based on record review and staff interviews, the facility failed to complete Physician Orders for Scope of Treatment (POST) forms accurately for Residents #14, #72, #30. This was found to be true for 3 of 32 care plans reviewed. Resident Identifiers #14, #72, #30. Facility Census:88 . Findings included: a) Resident #14 On 11/12/24 at 2:49 PM during record review on 11/12/24 found the [NAME] Virginia POST form had Resident #14 marked as a female Further record review on 11/12/24 of the Resident Profiled and Admission Record revealed the resident as a male. During an interview on 11/12/24 with the Director of Nursing (DON) #94 confirmed the POST form was coded incorrectly and stated yes that's not correct. b) Resident #72 On 11/12/24 at 3:20 PM, a record review was completed for Resident #72. The review found the Physician's Order for Scope of Treatment (POST) did not list the preparer's signature and date. On 11/13/24 at 10:00 AM, the Director of Nursing (DON) was notified. The DON stated, we will get this corrected. c) Resident #30 At approximately 4:00 PM on 11/11/24, a review of advance directives were conducted for Resident #30. During the review, it was noted the Social Worker (SW) that prepared the form, signed the POST form for Resident #30, but struck out her name. At approximately 1:15 PM on 11/14/24, the Director of Nursing (DON) acknowledged the inaccurate POST form.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49467 Based on observation and staff interview, the facility failed to properly implement infection control procedures to prevent the spread of infectious diseases. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents residing in the facility. Facility census: 88. Findings included: A) Resident #10 At approximately 10:18 on 11/12/24, before entering the room of Resident #10, a sign was noticed on the door for droplet precautions. Among the precautions on the sign was KEEP DOOR CLOSED. The door to Resident #10's room was observed as being open. At approximately 10:20 AM, Licensed Practical Nurse (LPN) #120 acknowledged the precaution on the sign and the door being open. LPN #120 stated I'm sorry, I guess I must have missed that. I'll close it now.